Health Professions Quality Assurance Division
PO Box 1099
Olympia, WA 98507-1099

Special Examination Requirements

If you have a disability that requires special accommodation at either the written or oral portion of the examination, please complete this form and return it with your application.

Name: _____
LAST FIRST MIDDLE

Mailing Address: _____

City, State & Zip Code: _____

Phone Number: _____ Date of Birth: _____/_____/_____
WHERE YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS

Do you have a condition requiring special attention? ☐ Yes ☐ No

- ☐ Vision Problems
- ☐ Physical Disability
- ☐ Learning Disability
- ☐ Other _____

What special services will you need? _____

Please have your physician, optometrist, learning specialist, etc., complete the reverse side of this form.

_____
Signature of Applicant

_____
Date

If you have any questions or concerns, please contact our office at Department of Health, Psychology Program, PO Box 47869, Olympia, WA 98504-7869, (360) 236-4910.

Special Examination Requirements

To the Physician, Optometrist, Learning Specialist, etc.:

Please complete the following form regarding the candidate for the licensing/certification examination.

Applicant's Name _____ requires the following special needs for the written/oral portion of the licensure/certification examination:

- ☐ Extra Time
- ☐ Reader
- ☐ Writer
- ☐ Other _____

_____

_____

_____

_____

_____ _____

Your Name and Date (Please Type or Print Legibly)

_____

Written Signature and Title

_____

_____

_____

Telephone Number: _____

(FOR CONTACT DURING BUSINESS HOURS)